Attachment I

MHSA Housing Certification Application

Section 1. Referral Source

☐ MHSA Housing Program ☐ MHSA Housing Trust Fund ☐ Both

FOR OFFICE USE ONLY

Date Received ____/____/____

☐ Approved ☐ Denied Date ____/____/____

Initials_____

Referring Agency

Address City Zip Code

Contact Name Phone

Email

Section 2. Applicant Information

Name Phone Number/Message Number Date

Social Security Number Date of Birth Gender

Mailing Address (Address Where Mail Can Be Received) City Zip Code IS Number

Section 3. MHSA Eligibility Criteria (check all that apply)

☐ Adult or older adult with a severe and persistent mental illness (as defined in Welfare and Institutions Code 5600.3)

☐ Child/adolescent with severe emotional disturbance (as defined in Welfare and Institutions Code 5600.3)

☐ Individual has a co-occurring mental health and substance abuse disorder

☐ Current mental health service provider: _____

☐ Tenant has declined mental health services

Section 4. Homeless or At Risk of Homelessness Status (check all that apply)

Length of most recent episode of homelessness:_____

☐ Living on the streets

☐ Living in an emergency shelter or in transitional housing

☐ Living in an institutional setting (e.g. jail, juvenile hall/camp, psychiatric hospital or IMD) and will be homeless upon release

☐ Lacking a fixed, regular and adequate nighttime residence

☐ Temporarily living in a residential care facility

☐ Facing eviction & unable to identify a new residence

☐ Living in an overcrowded setting in which they do not hold a lease

☐ Living in substandard housing subject to an official notice to vacate

☐ Paying more than 50% of income in housing costs

☐ "Doubling up" or "couch surfing" due to economic hardship

☐ Living in motels, hotels, trailer parks or camp grounds

☐ Victim of domestic violence who is unable to obtain housing

☐ Other (please explain):_____

_____

Section 5. Income

Sources (check all that apply):

☐ SSI ☐ VA ☐ Unemployment

☐ SSDI ☐ Social Security ☐ None

☐ SDI ☐ CalWORKS ☐ Other (list below): _____

☐ GR ☐ Wages/salary

Benefit Establishment Status (if applicable):

Type of benefit:_____

Date Application Submitted ____/____/____ ____Pending ____Denied ____Appealed

Type of benefit:_____

Date Application Submitted ____/____/____ ____Pending ____Denied ____Appealed

Section 6. Desired Location

Address of Unit Requested (if known):

Street Address Unit/Apt.

City State Zip

Requested Service Area(s):

☐SA 1: Antelope Valley ☐SA 2: San Fernando/Santa Clarita Valleys ☐SA 3: San Gabriel Valley ☐SA 4: Metro ☐SA 5: West ☐SA 6: South ☐SA 7: East ☐SA 8: Harbor

Section 7. Household Size

(attach additional page if necessary)

☐ 1 person ☐ 2 people ☐ 3 people ☐ 4 people ☐ Other _____

If more than one person is checked above, complete the following:

Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Date of Birth:	Date of Birth:	Date of Birth:
Age:	Age:	Age:

Signed Authorization to Disclose Client's Protected Health Information attached ☐ Yes ☐ No

This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Codes, Civil Codes and Health Information and Portability Act (HIPPA) Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.

Applicant Signature **Date** **Signature of Representative from Referring Agency** **Date**

Send to: Department of Mental Health Housing Policy & Development Attn: Housing Coordinator 695 S. Vermont Ave, 10th floor Los Angeles, CA 90005 fax (213) 637-2336

rev 8-5-09